

CLAIMANT'S NAME Terri Delgadillo		SSAN OR EMPLOYEE NUMBER* [REDACTED]		DEPARTMENT Developmental Services	
POSITION Director		CB/D NUMBER E99		DIVISION OR BUREAU DIRECTOR'S OFFICE	
RESIDENCE ADDRESS* [REDACTED]		HEADQUARTERS ADDRESS 1600 9th Street, Room 240		INDEX NUMBER 473-001	
CITY [REDACTED]		STATE CA		ZIP CODE 95814	

[illegible]**CLAIM TOTAL**

\$ 96.50

(12) NORMAL WORK HOURS

8a to 5p

(13) PRIVATE VEHICLE LICENSE NUMBER

(14) MILEAGE RATE CLAIMED

\$0.55

AGENCY ACCOUNTING OFFICE
USE ONLY
PAID BY REVOLVING FUND CHECK NUMBER

(15) I HEREBY CERTIFY That the above is a true statement of the travel expenses incurred by me in accordance with DPA rules in the service of the State of California. If a privately owed vehicle was used, and if mileage rates exceed the minimum rate. I certify that the cost of operating the vehicle was equal to or greater than the rate claimed, and that I have met the requirements as prescribed by SAM Sections 0750, 0752, 0753 and 0754 pertaining to vehicle safety and seat belt usage.

CLAIMANT'S SIGNATURE

DATE _____

(16) SIGNATURE OF OFFICER APPROVING TRAVEL AND PAYMENT

DATE _____

(17) SPECIAL EXPENSE AUTHORIZATION - SIGNATURE and TITLE (See Item 17 on reverse)

DATE _____